

Manufacturing & Assembling Supplemental Application



Insured: _____ FEIN: _____ Eff. Date: _____
 Contact Name & Title: _____ Tel.#: _____ Fax.#: _____
 Website Address: _____

Years in business: _____ #of Locations: _____
 Description of operations: _____
 Union: Yes No If yes, name of Union: _____
 Current number of employees: Full time _____ Part time _____ Seasonal _____ Volunteers _____
 Percent of employee turnover in the last 12 Months: Full time _____ Part time _____
 Employee staffing expectation over the next 12 months: Full time _____ Part time _____
 Average hourly wage in Governing Class: Full time \$ _____ Part time \$ _____
 Average hourly wage in Clerical Class: Full time \$ _____ Part time \$ _____
 Average hourly wage in Sales Class: Full time \$ _____ Part time \$ _____
 Has the insured ever been in bankruptcy? Yes No
 If yes, Explain _____

Are ALL employees eligible Y/N; if no the who? _____

	% paid by employer	% of participation
Group Health <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Paid sick leave <input type="checkbox"/> Yes <input type="checkbox"/> No	Vacation <input type="checkbox"/> Yes <input type="checkbox"/> No	Retirement / Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Healthcare provider: _____		
Do you use specific:	Clinic _____	Physician _____
		Emergency room _____
Full time nurse maintained on staff?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
CPR training provided?: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Safety program / IIPP compliant with SB 198 Yes No
 Return to light duty plan Yes No
 Return to full time modified work plan Yes No
 Designated full time safety director Yes No Name: _____
 Safety meetings held for all employees Yes No Frequency of meetings: _____
 Safety training for all employees Yes No Incentive program for employees Yes No
 Personal protective safety equipment provided Yes No
 Supervisors are held accountable for injuries/accidents Yes No
 Accident investigation program in place Yes No

Employment application <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug/substance abuse <input type="checkbox"/> Yes <input type="checkbox"/> No
Reference checks <input type="checkbox"/> Yes <input type="checkbox"/> No	Audiometric Testing <input type="checkbox"/> Yes <input type="checkbox"/> No
Motor Vehicle Record Check <input type="checkbox"/> Yes <input type="checkbox"/> No	Pre/Post employment physical <input type="checkbox"/> Yes <input type="checkbox"/> No
Volunteer labor used <input type="checkbox"/> Yes <input type="checkbox"/> No	Pathogenic test (i.e. lead) <input type="checkbox"/> Yes <input type="checkbox"/> No
Temporary labor used <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic back test <input type="checkbox"/> Yes <input type="checkbox"/> No

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Hours of operation: _____ to _____ Number of daily shifts: _____
 Operation includes driving? Yes No Number of authorized drivers _____ No. of vehicles _____
 Types of vehicles driven _____
 Reason(s) for driving (delivery, sales calls, etc.)? _____
 Frequency of driving: Daily Weekly Other _____
 Driving radius: < 50 miles 51-100 miles 101-250 miles > 250 miles
 Frequency of MVY checks _____ Participation in CHP Pull program Yes No
 Driver acceptability standards have been established Yes No
 Vehicles inspection / maintenance program Yes No Frequency _____
 Vehicle maintenance performed is performed by employees Yes No
 Employees take vehicles home Yes No

Payroll Current Year _____
1st Prior Year _____
2nd Prior Year _____
3rd Prior Year _____

Premium Current Year _____
1st Prior Year _____
2nd Prior Year _____
3rd Prior Year _____

Any travel out of state? Yes No No.# of employees who travel: _____ Frequency: _____
 Purpose: _____

Machine guarding: Point of operation: Yes No
 Drive mechanism: Yes No
 Moving Parts: Yes No Lock out/tag out: Yes No
 % of – Point of operation guarding: _____
 Moving parts _____ Drive mechanism: _____

Material handling exposure: Yes No
 Lifting: Below 50 lbs. Above 50 lbs. _____
 Off premises: Yes No Percentage _____

TYPE OF MECHINES USED?

Where / What: _____
 Personal Protection Equipment Provided? Yes No
 Used enforced? Yes No

Any Piece-work or home-based work? Yes No
 If yes, explain: _____

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Does insured work within 2 miles of the following building or facilities:

- Government or Military base: Yes No
- Financial Institutions including national/regional stock exchange Yes No
- Sport Stadiums/ Arenas and Theme Parks Yes No
- Major Bridges, Tunnels or Dams Yes No
- Utilities or Power Generation Plants Yes No
- Transportation Hubs, Railroads, Airports or Shipping Yes No
- Historic/Symbolic buildings, monuments or parks Yes No

EXPOSURE INFORMATION – PREMISES – FIX LOCATION – EMPLOYEES

Total number of employee's: _____

State	Location #	Payroll	Total # of Employees	# of Shifts	Maximum # of Employees Per Shift	Type of Building (See List Below)	Year Built	# of Stories	Floors Occupied
		\$							
		\$							
		\$							
		\$							
		\$							
		\$							
		\$							
		\$							
		\$							

If additional locations exist please include on a separate form.

Type of Building: (1.) Steel 3 stories or greater (2.) Frame 3 stories or less (3.) Concrete tilt up

- 1. Has the Insured previously participated in a Medical Provider Network? Yes No
- 2. Is the insured willing to participate in a Medical Provider Network? Yes No

Comments:

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND CERTIFIES THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE CERTIFIES THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

SIGNATURE

DATE